STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. BUILDING _____ B. WING _____	C 05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	**4171 FOREST POINTE CIR AVON, IN 46123**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00149048.

Complaint IN00149048 Substantiated. No deficiencies related to the allegations are cited.

Survey dates: May 21, 22, 2014

Facility number: 000141
Provider number: 155236
AIM number: 100283860

Survey team:
Connie Landman RN-TC

Census bed type:
SNF: 23
SNF/NF: 119
Total: 142

Census payor type:
Medicare: 32
Medicaid: 86
Other: 24
Total: 142

Sample: 6

Avon Health & Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00149048.

Quality Review 05/23/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE